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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07183

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton 45 da.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma Irene Bailey</u>		4. DATE OF DEATH Month Day Year <u>6 11 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1925</u>
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clayton Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Viola Coursey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-22-8073</u>	
17. INFORMANT <u>M. Clayton Bailey - St. Michaels, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circumstances</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Pancreas</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u> <u>10 wks.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 April 1961</u> to <u>6-11</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive and <u>6-19</u> 19 <u>61</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>R. Lane Wroth</u>		22b. DATE SIGNED <u>6/12/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>		22d. ADDRESS <u>St. Michaels, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>June 17, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Ashiel Coster, Jr.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 14 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
TO BE COMPLETED BY THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled in by the funeral director.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>3 1/2 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Samuel</i> Middle <i>O</i> Last <i>BARNES</i>		4. DATE OF DEATH Month <i>June</i> Day <i>7</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 28, 1880</i>
9. AGE (In years last birthday) <i>81</i> yrs.	IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min.	IF UNDER 24 HRS. Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joseph Barnes</i>		14. MOTHER'S MARRIED NAME <i>Abigail Merrick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mrs. Samuel Barnes</i> Address <i>Talbot Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>Unknown</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-5</i> <i>1961</i> , to <i>6-8</i> <i>1961</i> , that (I) (we) last saw the deceased alive on <i>6-7</i> <i>1961</i> , and that death occurred on <i>5</i> <i>PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Trever</i>		22b. DATE SIGNED <i>6-8-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>		22d. ADDRESS <i>M. D. Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 9, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Springfield Cem</i>		23d. LOCATION (City, town, or county) (State) <i>Easton Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Maureen E. Newman &amp; Son</i> ADDRESS <i>Easton Md.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 12 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles S. Hanna</i>	



TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) First <b>Mauda</b> Middle <b>Pritchett</b> Last <b>Brumbaugh</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21, 1890</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>26</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles E. Pritchett</b>		14. MOTHER'S MAIDEN NAME <b>? Russell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-32-7051</b>	
17. INFORMANT <b>Arthur Brumbaugh</b>		Address <b>Greensboro, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Basilar skull fracture</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>11 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell, striking head - presumably had CVA and fell as result of same</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) <b>Greensboro</b> (County) <b>Caroline</b> (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>6/14/1961</b> to <b>6/26/1961</b> , that (I) (we) last saw the deceased alive on <b>6-26-1961</b> , and that death occurred at <b>12:03 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert W. Trever</b>		22b. DATE SIGNED <b>6/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert W. Trever M.D.</b>		22d. ADDRESS <b>Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-28-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		23d. LOCATION (City, town, or county) <b>Greensboro</b> (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Boulas</b>		ADDRESS <b>Greensboro, Md.</b>	
25a. REC'D BY REGISTRAR <b>JUN 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Christina S. Farris</b>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived). If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. LENGTH OF STAY IN lb <b>10 min</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>EMMA</b> Last <b>BRUMMELL</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr: 20, 1914</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George White</b>				14. MOTHER'S MAIDEN NAME <b>Nannie Wing</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, say of what branch) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-10-6429</b>		17. INFORMANT <b>Mr. Mary L. Brown - Trappe, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Submyocardial infarction &amp; edema</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c) <b>Hypertension &amp; arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>obesity</b> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (a) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (b) (we) last saw the deceased alive on <b>19</b> , and that death occurred <b>12:35 A.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. C. H. Schmidt</b>				22b. DATE, SIGNED <b>5 June 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>				22d. ADDRESS <b>Easton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>June 7, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trappe Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Trappe, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Washell, Easton, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

07187

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1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1 CHEW AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>William James Burrows</u>				4. DATE OF DEATH Month Day Year <u>June 17 1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>212-12-3474</u>		11. BIRTHPLACE (State or foreign country) <u>ST. MICHAELS MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WILLIAM H BURROWS</u>				14. MOTHER'S MAIDEN NAME <u>GEORGIANNA STOKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>none</u>				16. SOCIAL SECURITY NO. <u>212-12-3474</u>		17. INFORMANT Address <u>Mrs Elton Harrison, St. Michaels Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized carcinomatosis &amp; cachexia</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-7-61</u> to <u>6-17-61</u> , that (I) (we) last saw the deceased alive on <u>6-17-61</u> and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm M Reeser</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>6-19-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wm M Reeser</u>				22d. ADDRESS <u>St Michaels Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-20-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>St. Michaels Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>17 Hambleton Harrison, St. Michaels, Md</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 22 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
 15M 9/59

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

7193

C7188

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg - Rural</b>	
c. LENGTH OF STAY IN 1b <b>22 hrs 30 min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		d. STREET ADDRESS <b>River Road</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Clark</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1961</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1863</b>
9. AGE (In years last birthday) <b>98</b> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer and Canner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sweaburg, Canada</b>	
11 BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles L. Clark</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Mrs. Harold Clark, Federalburg, Md., R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Pneumonia - type undetermined</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>(7)</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>17 June 1961</b> to <b>20 June 1961</b> . that (I) (we) last saw the deceased alive on <b>20 June 1961</b> , and that death occurred at <b>11:25 AM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Horston Harrison</b>		22b. DATE SIGNED <b>22 June 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>HORSTON HARRISON</b>		22d. ADDRESS <b>Cedar Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 22, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Federalburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. J. Thompson and Son Federalburg</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 26 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

DP



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7200

Items 8 & 9 from 0250

7/27/61 1wk

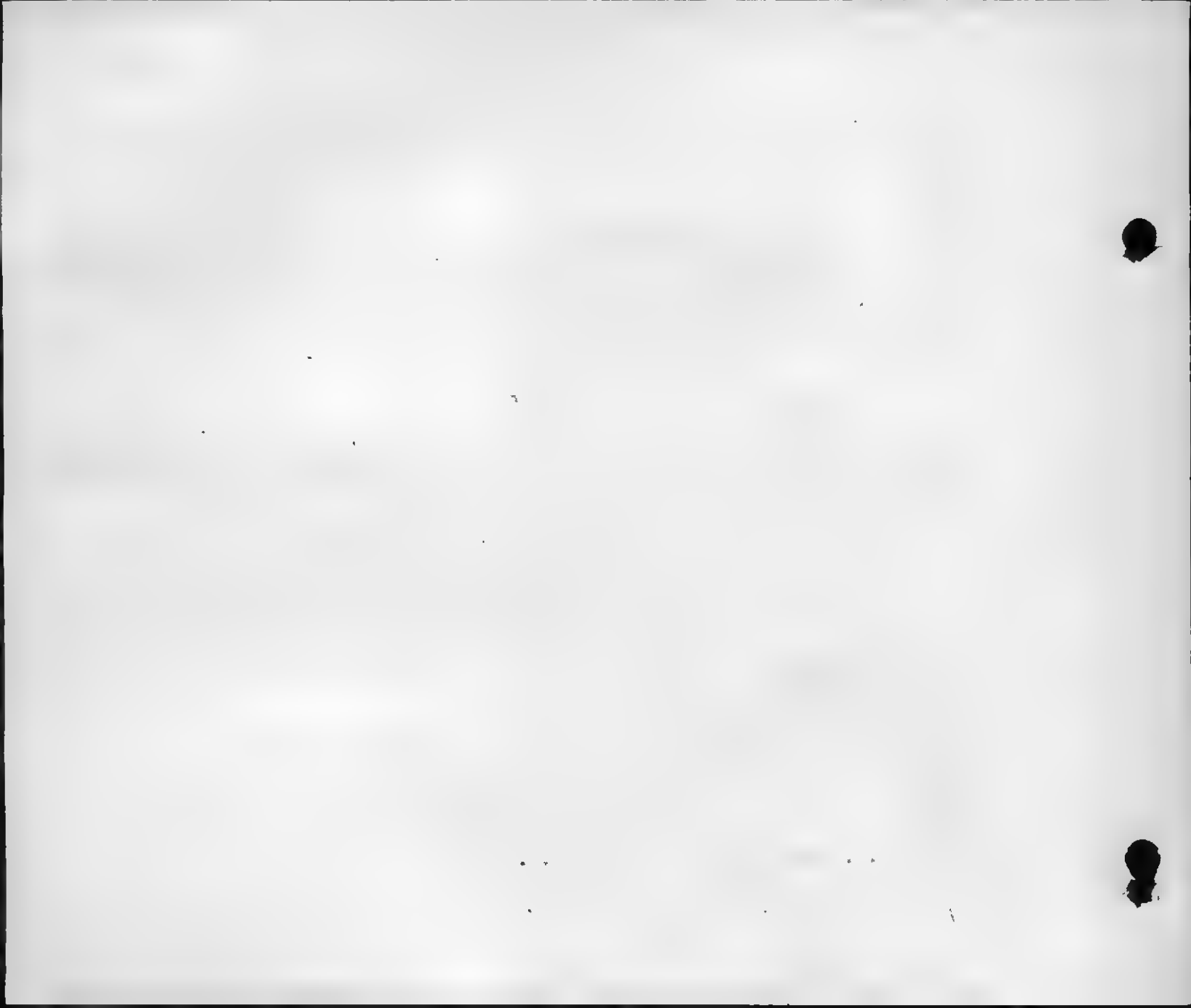
07189

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>Easton Memorial</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAJORIE</u> <u>Cornish</u>		4. DATE OF DEATH Month Day Year <u>June</u> <u>28</u> <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 19, 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Emory</u>		14. MOTHER'S MAIDEN NAME <u>Malisby Flamer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Gois Wilkins Easton, Md</u>	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		INTERVAL BETWEEN ONSET AND DEATH	
710.0 DUE TO (b) <u>Schrodema</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 1960</u> to <u>6/28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/28</u> , 19 <u>61</u> , and that death occurred at <u>5:30</u> M., from the causes and on the date stated above			
22a. SIGNATURE <u>L.W. Eglseder</u> M.D.		22b. DATE SIGNED <u>6/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>L.W. Eglseder</u> M.D.		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-2-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Copperville cem</u>		23d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Doherty</u> ADDRESS <u>Easton, Md</u>		25a. REC'D BY REGISTRAR <u>DAVID 5 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

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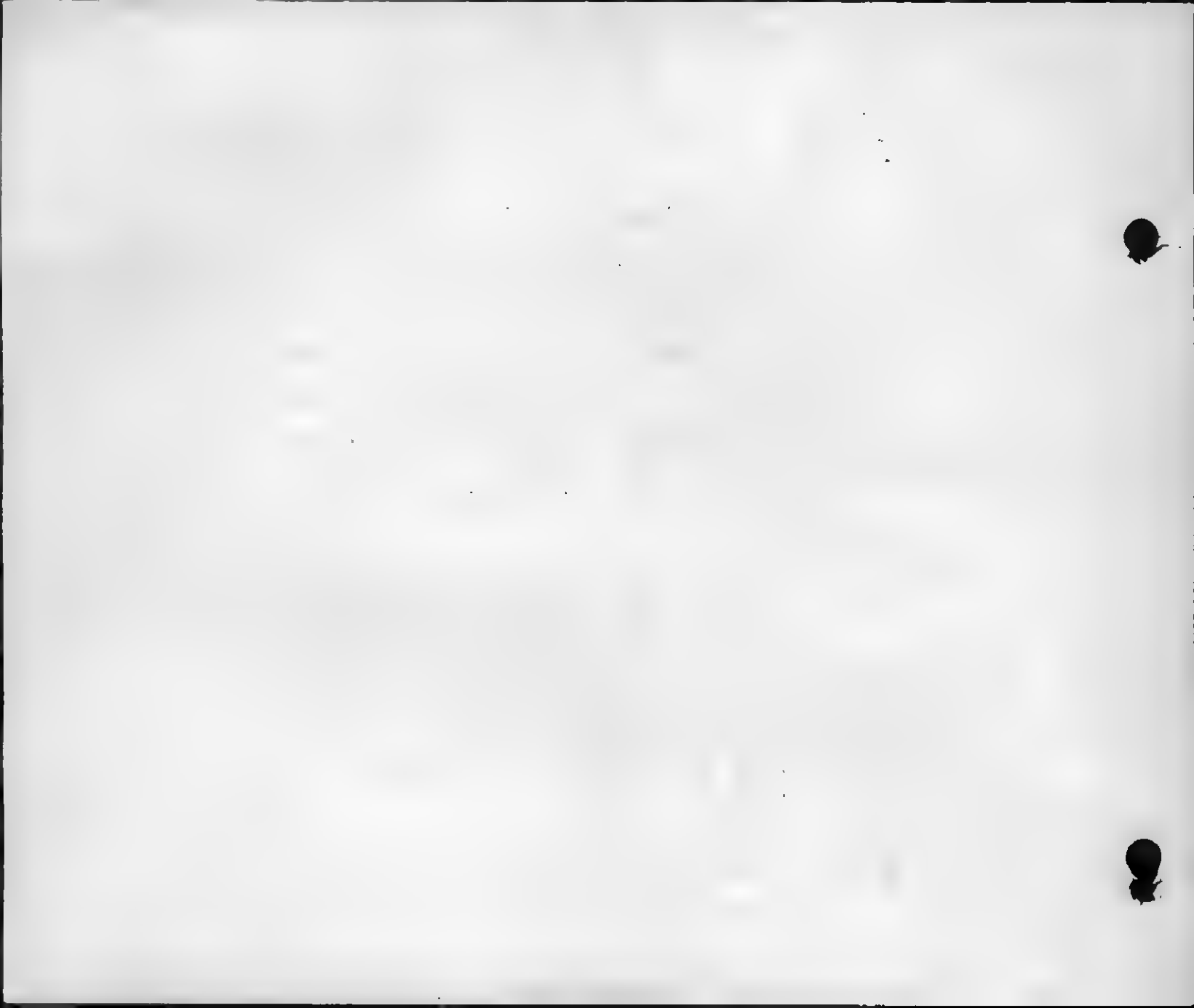


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
7201  
CERTIFICATE OF DEATH  
07190

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>15 hrs 5 min.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>		d. STREET ADDRESS <b>River Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Leticia</b> Last <b>Dickerson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1883</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Federalsburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Dickerson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Chambers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mary E. Francis, Suffolk, Virginia</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute cholecystitis</b> <b>S85</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12:35</b> to <b>12:45</b> that (I) (we) last saw the deceased alive on <b>June 22, 1961</b> and that death occurred at <b>12:45</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E. C. H. Schmidt</b> M.D.		22b. DATE SIGNED <b>24 June 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>		22d. ADDRESS <b>Easton, Maryland</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 27, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Franklin S. Son</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 3 '61</b>	
ADDRESS <b>Federalsburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Frank</b>	



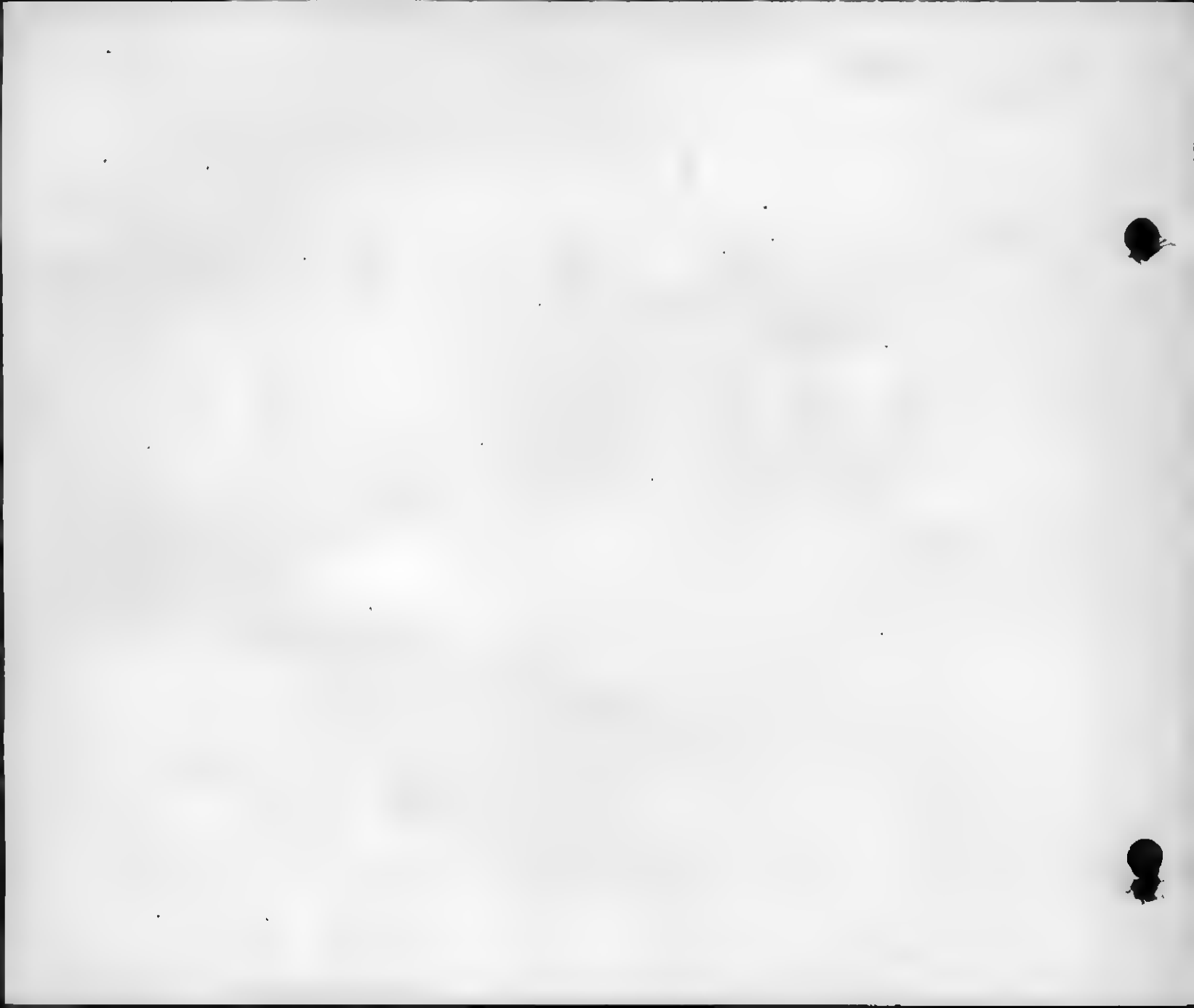
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07191

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN lb <u>5 hrs 35 min</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Easton (Rural)</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Ober Dulin</u>				4. DATE OF DEATH Month Day Year <u>June 10 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 17, 1885</u>	
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Dulin</u>				14. MOTHER'S MAIDEN NAME <u>Jellie Lord</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>1907-1911 Nov 17-30-9335</u>		17. INFORMANT Name Address <u>Mrs. Julia Bennett R.F.D. I Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>mesenteric thrombosis</u> <u>45010</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Blockage superior mesenteric artery</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs</u> <u>20 hrs</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>It operated upon lived for 4 hours p.o.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6:10</u> <u>1961</u> to <u>6:10</u> <u>1961</u> and that death occurred <u>6:10</u> <u>1961</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. T. B. Ambler</u>		M.D. <u>J. T. B. AMBLER</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/12/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. T. B. AMBLER</u>		22d. ADDRESS <u>Box 1025 Easton Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 12, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Keenan</u>				25a. RECEIVED BY REGISTRAR <u>Sow Easton, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



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2203

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07192

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON.</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON -</u>	
f. STREET ADDRESS <u>1 Gable Trailer Camp</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARON</u> Middle <u>W</u> Last <u>DURN.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 2, 1898</u>
9. AGE (In years last birthday) <u>62</u> yrs		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>16</u> Hours <u>16</u> Min <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter - Retired -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arnon Durn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Steyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>ARLO ADAMS ZOBHOLDEN RD.</u>		Address <u>INDIAN HEAD MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO (b) <u>A.S.C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Respiratory distress 2° to CHF &amp; Pulm. Embolism</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1, 1957</u> to <u>6/16, 1961</u> , that (I) (we) last saw the deceased alive on <u>6/16, 1961</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. J. Glander</u> M.D.		22b. DATE SIGNED <u>6/16, 1961</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/19/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>Sunderland Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co., 1400 Chapin Street, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>JUN 19 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Thos. A. Hanna</u>			





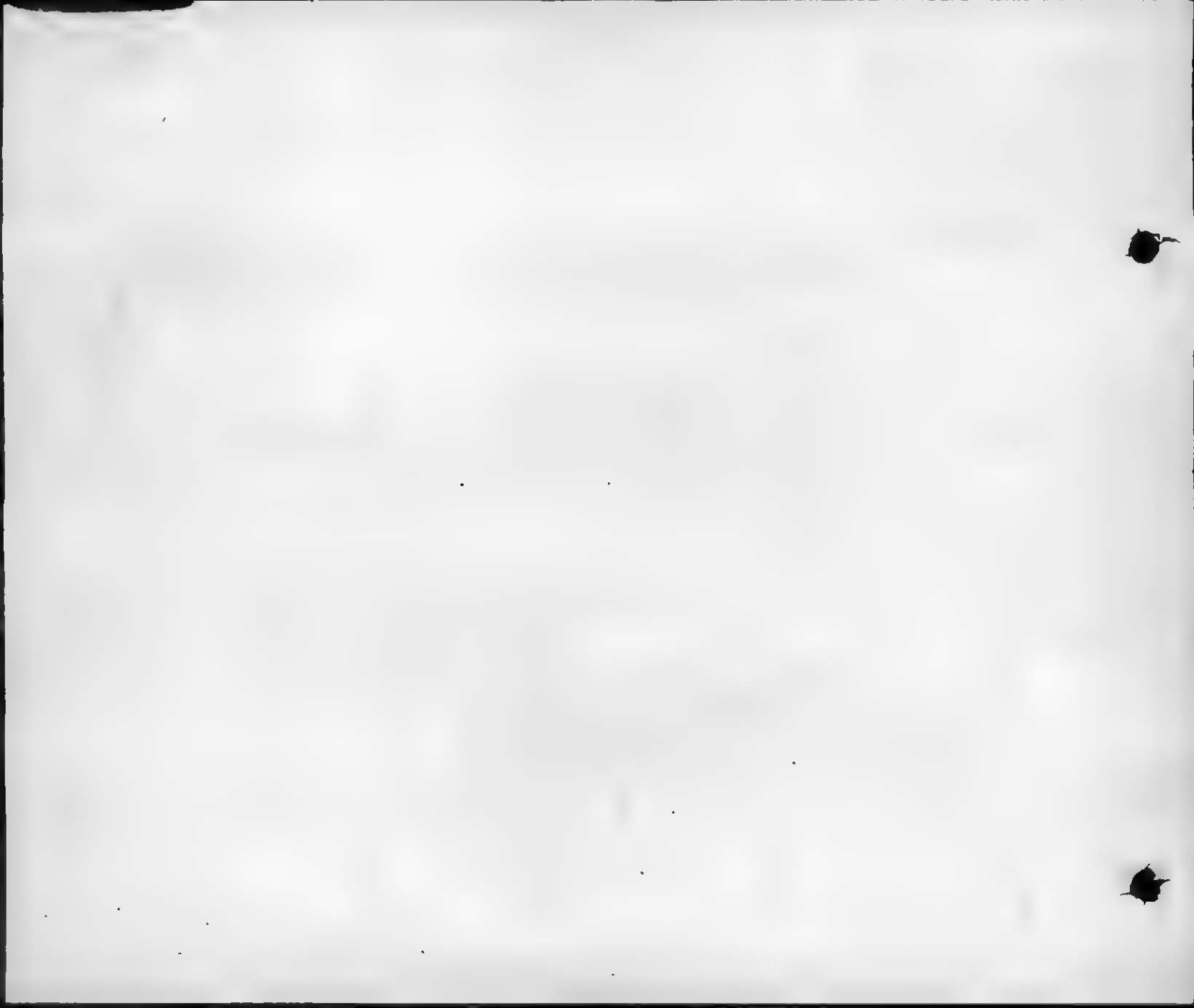
MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3204

07193

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institut an: Residence before admission) a. STATE <u>Mar, land</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wittman</u>	
c. LENGTH OF STAY IN 1b <u>1 hr 42 min</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Girl Fairbank</u>		4. DATE OF DEATH <u>June 23 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/61</u>
9. AGE (In years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR <u>1</u> Months <u>42</u> Days <u>1</u> Hours <u>42</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Neoph</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr Calvin E Fairbank</u>		14. MOTHER'S MAIDEN NAME <u>Viola Preiger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Viola Fairbank (Mother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity</u> 776X DUE TO (b) <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>776X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>776X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-23</u> to <u>6-23</u> , that (I) (we) last saw the deceased alive on <u>6-23</u> 19 <u>61</u> and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Michael</u> M.D.		22b. DATE SIGNED <u>6-26-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Michael</u>		22d. ADDRESS <u>St Michael</u>	
30. BURIAL, CREMATION, or other disposal <u>Incineration</u>		31. DATE THEREOF <u>9/28/61</u>	
32. NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u>		33. LOCATION (City, town, or county) (State) <u>Easton, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Incineration Easton, Memorial Hospital</u>		25. REC'D BY REGISTRAR <u>JUL 3 1961</u>	
26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE	







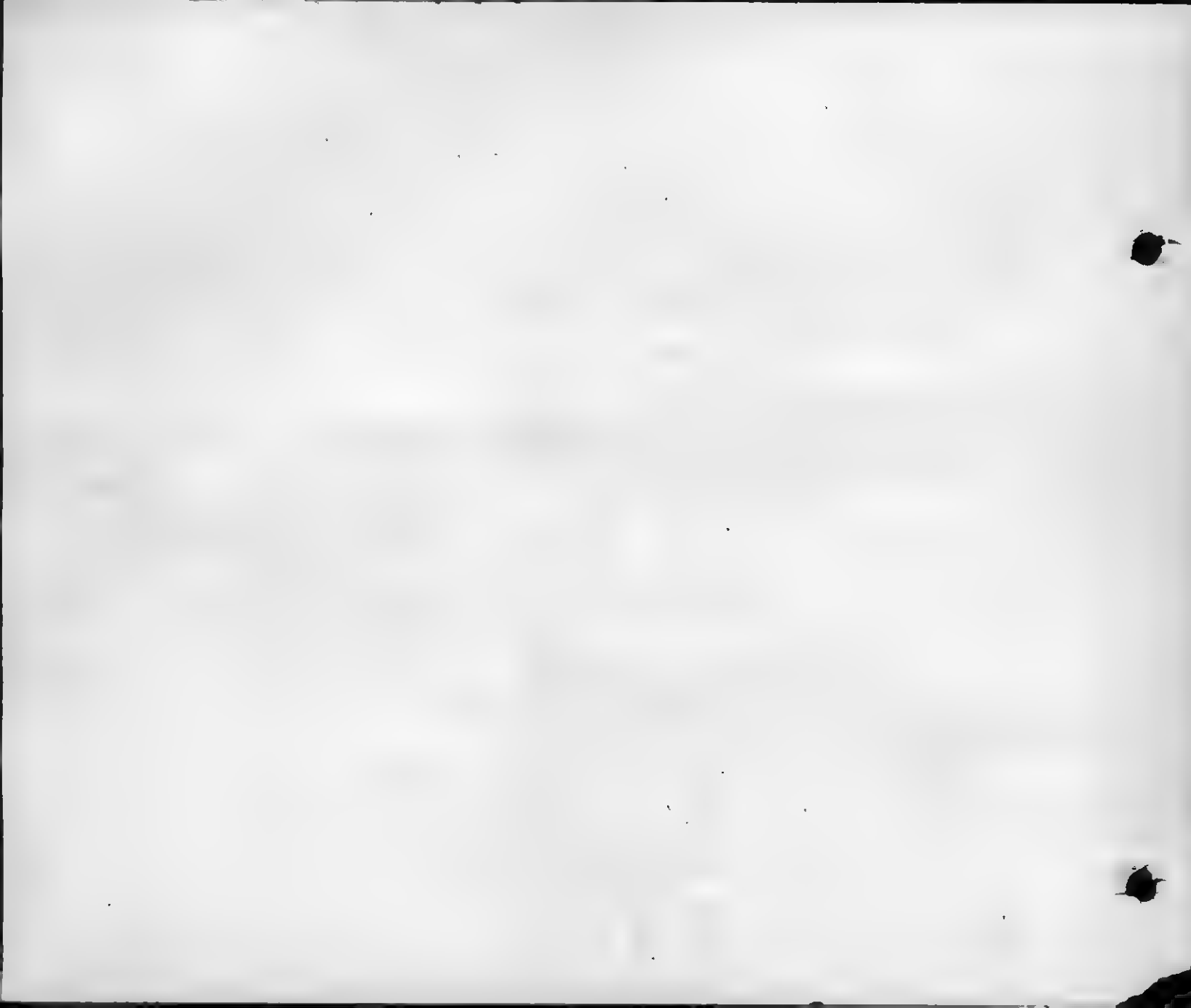
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7203

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07195

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON MEMORIAL HOSP.</u>		e. STREET ADDRESS <u>300 Talbot</u>	
3 NAME OF DECEASED (Type or print) First <u>Nenjietha</u> Middle <u>Frisby</u> Last <u>Frisky</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MARCH 11, 1872</u>
9 AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR <u>18</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAID</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Charles HASKINS</u>		14. MOTHER'S MAIDEN NAME <u>Katie Green</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>MARY Thomas</u>		Address <u>St. Michaels, Md.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertensive Cardiac Disease</u> (c) <u>Chronic Heart Fail</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>4 hr</u> <u>3 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 May</u> 19 <u>61</u> to <u>6 June</u> 19 <u>61</u> , that (I) ( <del>we</del> ) lost <u>1</u> saw the deceased alive on <u>6 June</u> 19 <u>61</u> , and that death occurred on <u>6 June</u> 19 <u>61</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>R. Lane Wroth</u>		22b. DATE SIGNED <u>4-25-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>		22d. ADDRESS <u></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 9, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashed</u>		25a. REC'D BY REGISTRAR <u>Easton Md -</u>	
25b. REGISTRAR'S SIGNATURE <u></u>		DATE <u>JUN 8 '61</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

7207  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

C7196

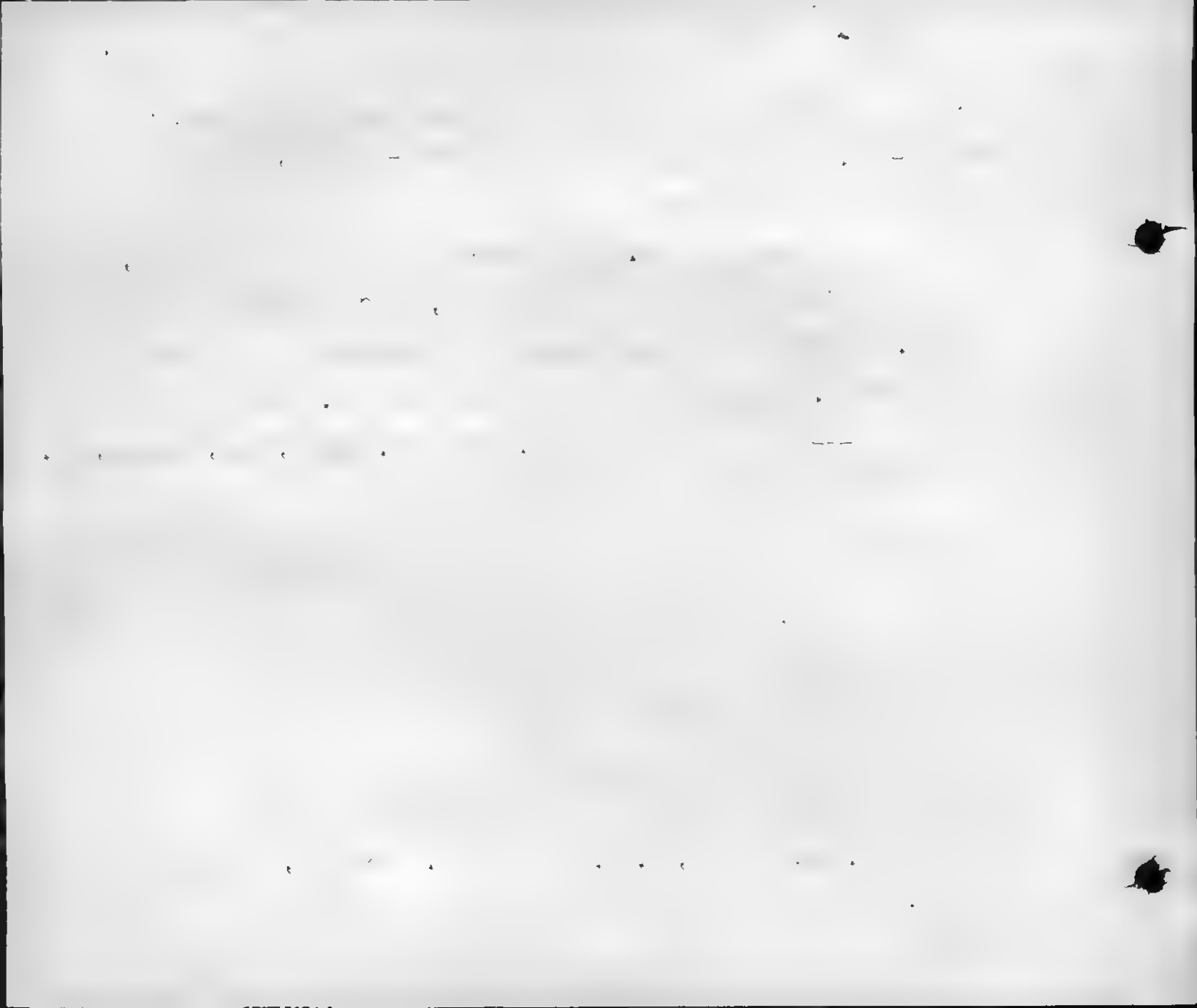
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Dorchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>18 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CAMBRIDGE MD RFD #2</i>	
		d. STREET ADDRESS <i>NONE</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Theresia Giese</i>		4. DATE OF DEATH <i>June 22 1961</i>	
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>WHITE</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>9/18/1879</i>	
9. AGE (in years last birthday) <i>81</i> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>	
11. BIRTHPLACE (State or foreign country) <i>AUSTRIA U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Memorial Hospital</i>		Address <i>EASTON MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Coronary Arteriosclerosis</i> DUE TO (c) <i>Generalized Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>a week</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Post operative - cholecystectomy</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March 1961</i> to <i>6/22 1961</i> that (I) (we) last saw the deceased alive on <i>6/22 1961</i> and that death occurred at <i>6:30 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>T. J. Gluden</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>6/24/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>DORCHESTER MATH HILL</i>		23d. LOCATION (City, town, or county) (State) <i>CAMBRIDGE MD</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>LECOMPT FURNERAL SERVICE</i>		25a. REC'D BY REGISTRAR <i>DATE JUL 3 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneiss</i>	

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7208  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
C7197

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL or give nearest town) <b>Rural - St. Michaels</b>		c. LENGTH OF STAY IN 1b <b>3 mo</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <b>Rio Vista Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>W.</b> Last <b>HILLEARY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 14, 1882</b>
9. AGE (In years last birthday) <b>79 yrs</b>		10. IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clarence W. Hilleary</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte O. Wheeler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>---</b>	
17. INFORMANT <b>Mrs. Robert W. Lewis, RFD, Trappe, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 2 X DUE TO <b>Generalize Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized Osteoarthritis</b> DUE TO (c) <b>Generalized Osteoarthritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>5 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Osteoarthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>2-22</b> 19 <b>61</b> , to <b>23 June, 1961</b> , that (I) (we) last saw the deceased alive on <b>22 June 1961</b> , and that death occurred at <b>2:10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R. Lane Wroth, M. D.</b>		22b. ADDRESS <b>St. Michaels, Maryland</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-26-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Petersville Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. H. Harrison, St. Michaels, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 28 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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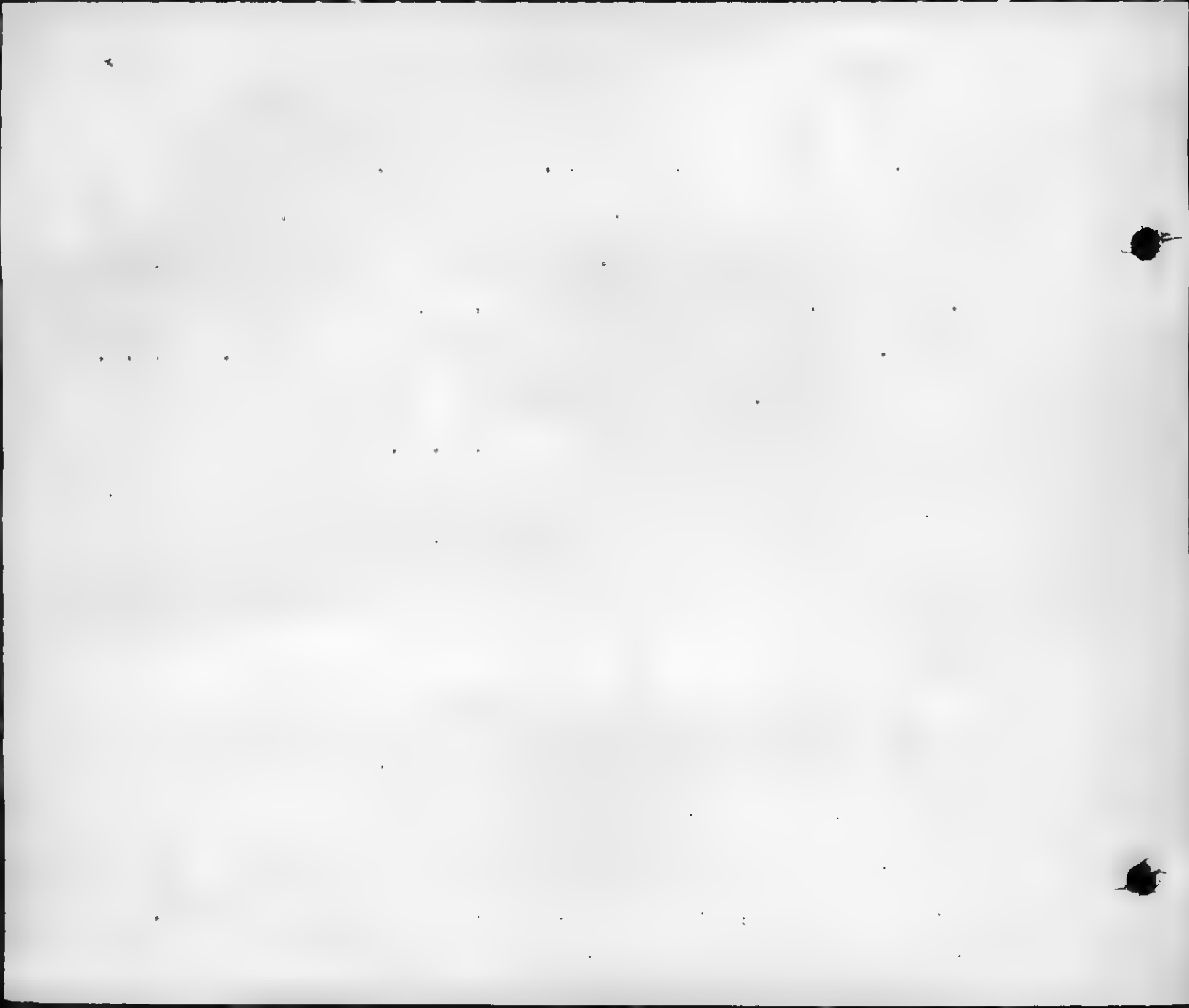
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

C7198

2209

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Michaels</b>				c. LENGTH OF STAY IN 1b <b>14 months.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rio Vista Nursing Home.</b>				e. STREET ADDRESS <b>Brooklets Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Morris</b> Last <b>Johns</b>				4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>1961</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1876</b>		9. AGE (In years last birthday) <b>84</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housekeeper</b>		11. BIRTHPLACE (State or foreign country) <b>Wilkes-Barre, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Morris.</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Mason</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>168-18-1476</b>		17. INFORMANT <b>Mrs. C. A. Kissinger, Easton, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cerebrovas. Thrombosis</b> <b>332X</b> DUE TO <b>cardioatherosclerotic vas. d.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19____ 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4-21</b> , 19 <b>60</b> to <b>6-24</b> , 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>6-24</b> , 19 <b>61</b> and that death occurred at <b>11:58</b> , from the causes and on the date stated above						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <i>[Signature]</i> M.D.				22b. DATE <b>6-26-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. M. P. Reese</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>June 28, 61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Rosemont.</b>		23d. LOCATION (City, town or county) (State) <b>Bloomsburg Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS <b>Easton Md</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 27 '61</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





7210

7210

Item 2 Film 0288

6/16/61

07199

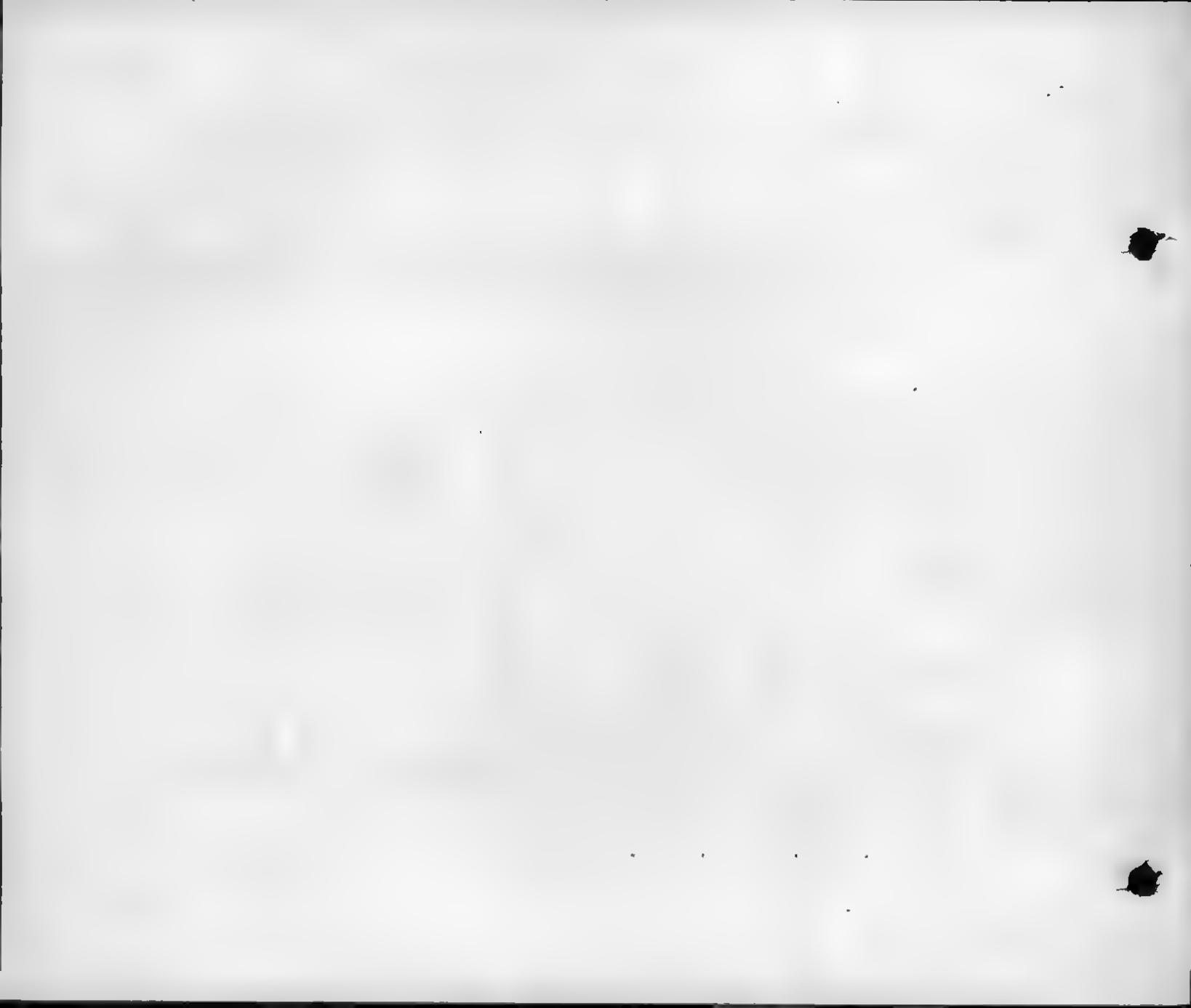
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Salisbury</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> c. LENGTH OF STAY IN 1b <i>15 day</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Caroline</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i> d. STREET ADDRESS <i>05 X-2</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Benjamin</i> Middle <i>Baine</i> Last <i>Maddox</i>		4. DATE OF DEATH Month <i>6</i> Day <i>5</i> Year <i>1961</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>B</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 19, 1887</i>	9. AGE (In years last birthday) <i>73</i> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>day laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>odd jobs</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Mrs. Benj. Maddox Denton, Md.</i> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Infection</i> <i>570.5</i> DUE TO <i>Refusal of food</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. <i>Severe diarrhea</i> DUE TO <i>operation 5/24/61 for intestinal obstruction + infected wound</i> (c) <i>11 + 5 days</i>					INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i> <i>6 days</i> <i>11 + 5 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>no</i> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/21/61</i> 19 to <i>6/5/61</i> 19 that (I) (we) last saw the deceased alive on <i>6/4</i> 1961 and that death occurred at <i>5:25 A</i> from the causes and on the date stated above.					
22a. SIGNATURE <i>J. T. B. Ambler</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>6/8/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>J. T. B. Ambler, M. D.</i>		22d. ADDRESS <i>Easton, Maryland Medical Arts Bldg</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 10, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Paul</i>	
23d. LOCATION (City, town, or county) <i>St. Paul near Denton, Md.</i>		23e. (State)		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Virgil Harrison</i>		ADDRESS <i>Denton, Md.</i>		25a. REC'D BY REGISTRAR <i>DATE JUN 13 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles E. Kiser</i>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

7211

07200

<b>1 PLACE OF DEATH</b> a. COUNTY <u>TALBOT</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>15 hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>New Castle</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington, Delaware</u> d. STREET ADDRESS <u>113 Sunset Drive, Delaire, Cal. D.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u></u> Last <u>McKeough</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>23</u> Year <u>1961</u>	
<b>5 SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7 MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/10/1909</u>
<b>9 AGE</b> (in years last birthday) <u>52</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>	<b>IF UNDER 24 HRS</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Asst. Vice-President</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Investments Bank</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Wilmington, Delaware</u>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <u>M.D.A.</u>	
<b>13. FATHER'S NAME</b> <u>William M. J. McKeough</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Jane T. McKeough</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		<b>16 SOCIAL SECURITY NO</b> <u>112-301-2242</u>	
<b>17 INFORMANT</b> <u>Catherine McKeough</u>		<b>Address</b> <u>Wilmington, Delaware</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> (b) <u>Old myocardial infarction</u> (c) <u>and fibrosis.</u> DUE TO <u></u> DUE TO <u></u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> (b) <u></u> (c) <u></u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) [this hospital] attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.</b>			
<b>22a SIGNATURE</b> <u>E. C. H. Schmidt</u> M.D.		<b>22b. DATE</b> <u>23 June 1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>E. C. H. Schmidt</u>		<b>22d. ADDRESS</b> <u>Easton, Maryland</u>	
<b>23a. BURIAL, CREMATION, REINTERMENT</b> (Specify) <u>6/27/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cathedral</u>	
<b>23d. LOCATION</b> (City, town, or county) (State) <u>Wilmington, Delaware</u>		<b>25a REC'D BY REGISTRAR</b> <b>DATE</b> <u>JUN 27 '61</u>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter A. ...</u>		<b>25b REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 hours after death. Page 1  
in by the funeral director, page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

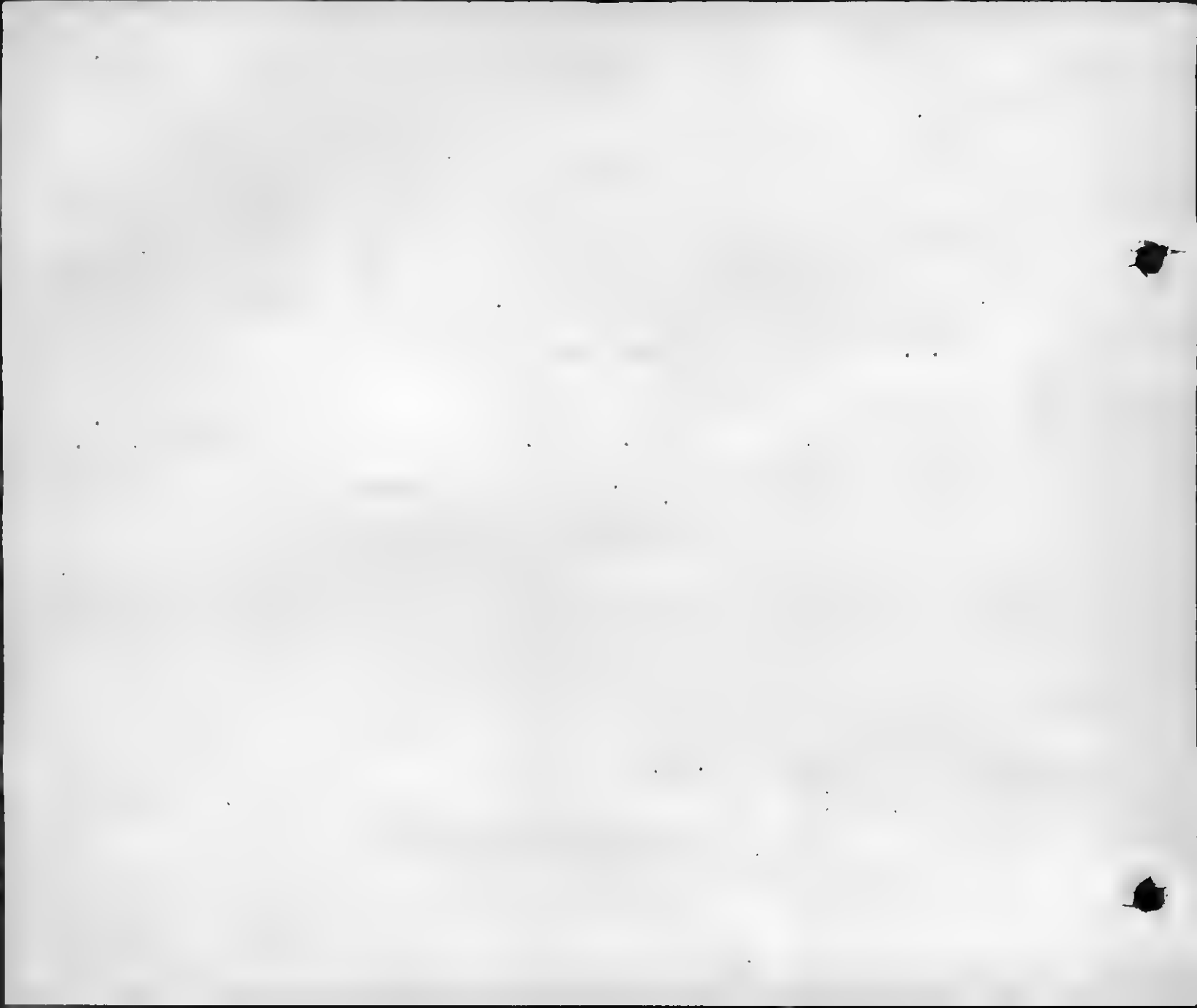
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7212

07201

1 PLACE OF DEATH a. COUNTY <b>TALBOT</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>27 days</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		d. STREET ADDRESS <b>WINDER POINT</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>HENRY C. R. MEAD</b>		4. DATE OF DEATH Month Day Year <b>JUNE 3 1961</b>					
5 SEX <b>M</b>	6 COLOR OR RACE <b>wh</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>JUN. 30, 1896</b>	9. AGE (in years last birthday) <b>64 yrs</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>M.D.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Psychiatrist</b>		11 BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE H. MEAD</b>		14. MOTHER'S MAIDEN NAME <b>HELEN CASTLE</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WWI</b>		16. SOCIAL SECURITY NO. <b>ukn.</b>		17 INFORMANT Address: <b>Winder Point"</b> <b>Mrs. Ellen Wassall Mead, Easton, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2440 Lymphosarcoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic lymphocytic</b> (c) <b>Leukemia</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
22a. SIGNATURE <b>E. C. H. Schmidt</b>		M. D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE <b>4 June 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>		22d. ADDRESS <b>Easton, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>6/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>W. Houghton Carroll</b>				ADDRESS <b>EASTON, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 8 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



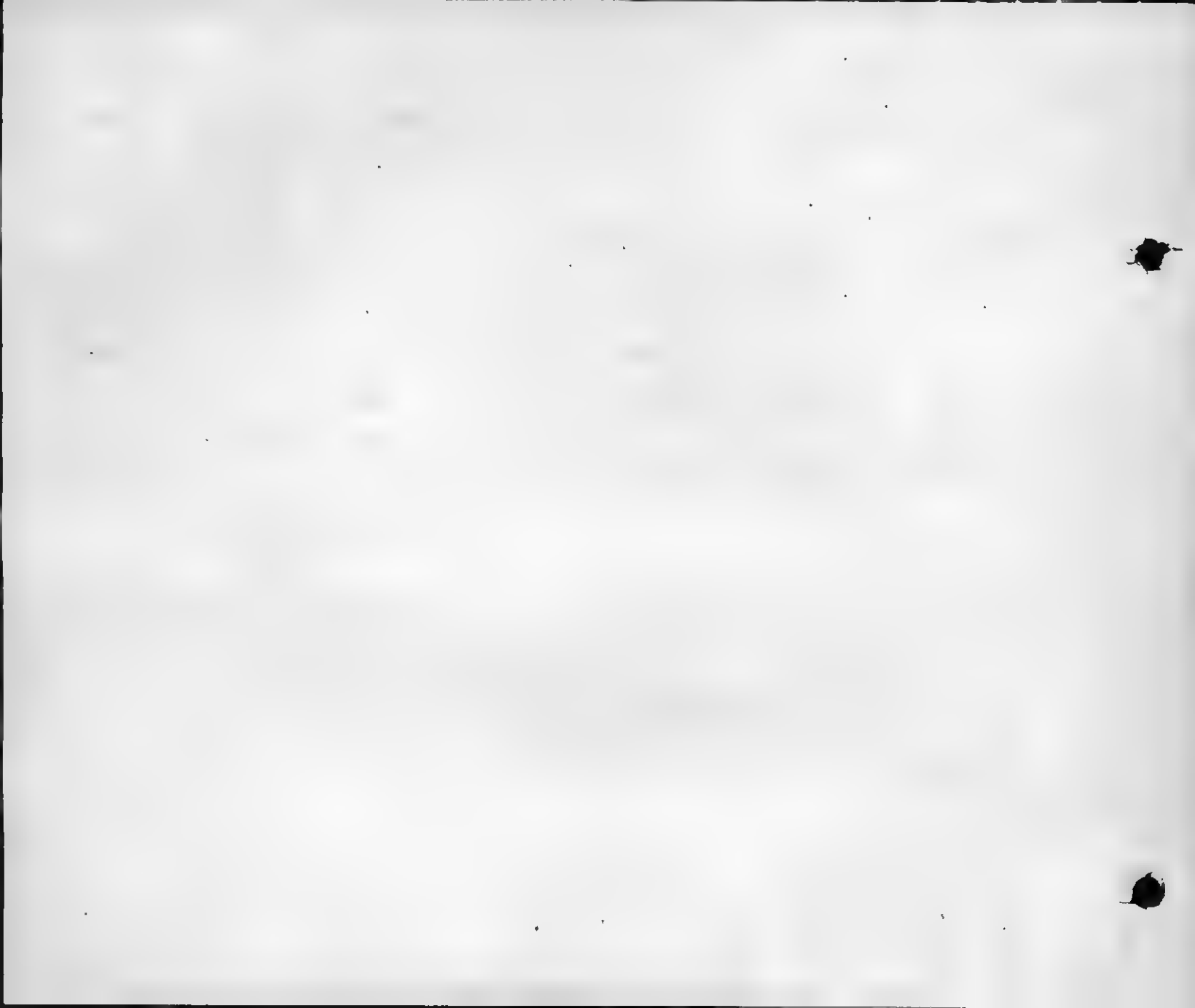
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

7213

07202

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>EASTON</b>				c. LENGTH OF STAY IN 1b <b>1 hr. 5 min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>TURPIN</b> Last <b>Mitchell</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 28 - 1907</b>	
9. AGE (In years last birthday) <b>54</b> yrs		IF UNDER 1 YEAR Months <b>54</b> Days <b>17</b> Hours <b>17</b> Min.		IF UNDER 24 HRS Months <b>54</b> Days <b>17</b> Hours <b>17</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer owner</b>		11. BIRTHPLACE (State or foreign country) <b>Queen Anne's Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Turpin Mitchell</b>				14. MOTHER'S MAIDEN NAME <b>Eloa Melby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Arthur Elizabeth Mitchell</b>		Address <b>Centerville Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>ventricular infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>suicide -</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Myocardial infarction</b>				(b) <b>1 hr.</b>			
(c) <b>Alcoholism causing thrombosis</b>				(c) <b>1 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>life</b> to <b>17 June 1961</b> , that (I) (we) last saw the deceased alive on <b>17 June 1961</b> , and that death occurred at <b>10:35 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Thomas Harrison</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>17 June 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THURSTON HARRISON</b>				22d. ADDRESS <b>Easton, Maryland</b>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 20 - 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill</b>		23d. LOCATION (City, town, or county) (State) <b>Easton Talbot Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Donnell H. Bauling</b>				25a. REC'D BY REGISTRAR <b>JUN 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>	

TO BE COMPLETED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FURNISH DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
07203

1 PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>23 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>1111 West Chestnut ST</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Ethel</i> Middle <i>M</i> Last <i>ORR</i>		4. DATE OF DEATH Month <i>JUNE</i> Day <i>23</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/9/1890</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>GOVT. CLERK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. GOVT.</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Louis Miller</i>		14. MOTHER'S MAIDEN NAME <i>Eliza Robbins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>?</i>		16. SOCIAL SECURITY NO <i>?</i>	
17. INFORMANT <i>A. Harrison, St. Michaels Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>199X</i> <i>cachexia - severe</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>adenocarcinomatosis</i> (c) <i>Generalized</i>		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-1-1961</i> to <i>6-23-1961</i> that (I) (we) last saw the deceased alive on <i>6-23-1961</i> and that death occurred at <i>3:47</i> M, from the causes and on the date stated above			
22a. SIGNATURE <i>Wm B. Reeser</i> M.D.		22b. DATE SIGNED <i>6-26-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Wm B. Reeser</i>		22d. ADDRESS <i>St. Michaels Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-27-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Christ Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Michaels Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>A. Harrison</i>		25a. REC'D BY REGISTRAR <i>St. Michaels Md.</i> DATE <i>JUN 29 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

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MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

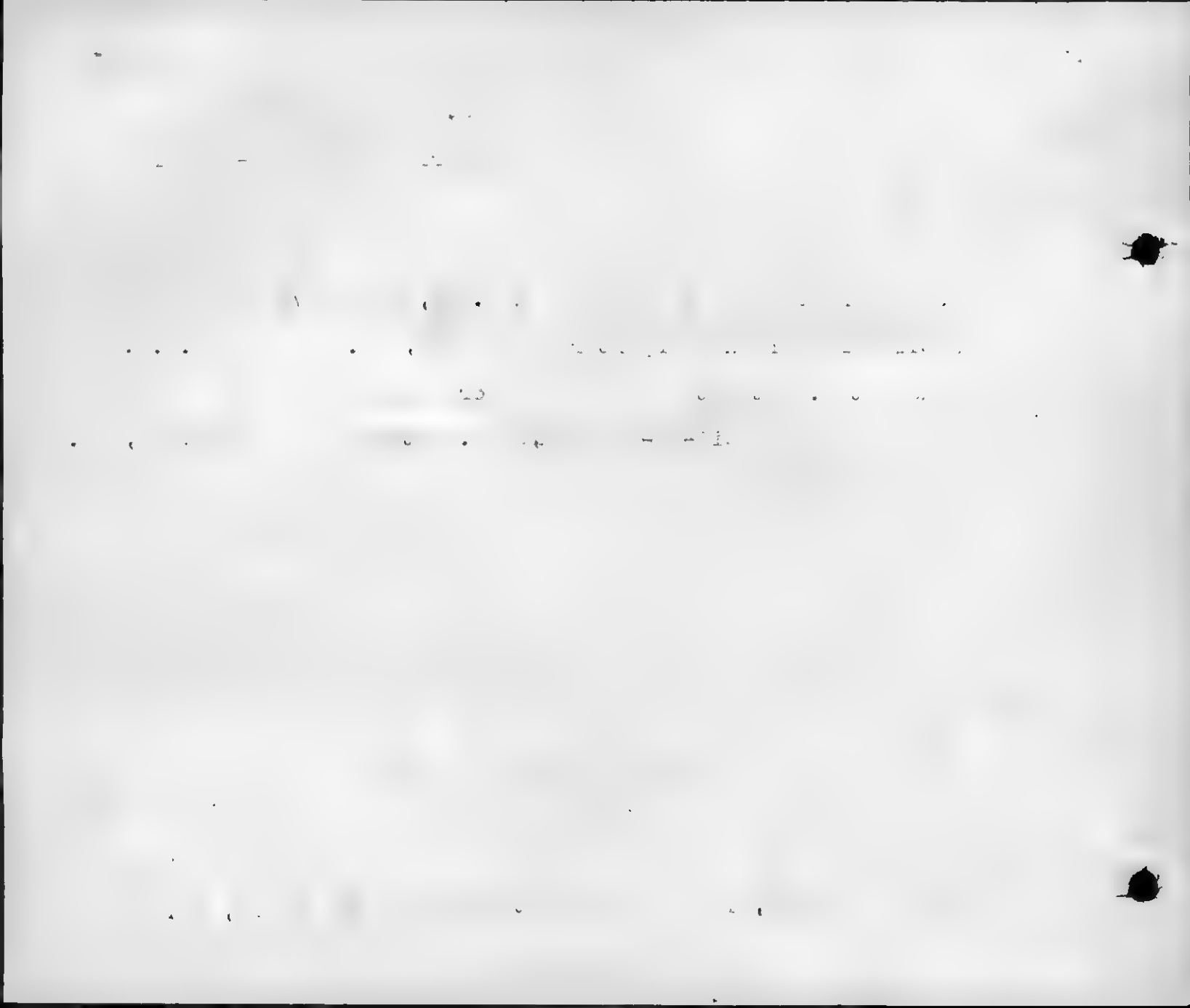
07204

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>American Corner --rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>				d. STREET ADDRESS <b>none</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Baynard</b> Last <b>Patchett</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 14, 1888</b>	
9. AGE (in years lost birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min <b>72</b>		IF UNDER 24 HRS Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min <b>72</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer and carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Easton, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Robert C. Patchett</b>				14. MOTHER'S MAIDEN NAME <b>Georgianna Boyles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-18-2122</b>		17. INFORMANT <b>James C. Patchett</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Nephrositis</b> DUE TO (b) <b>Hydrosonephrosis &amp; hydroureter</b> DUE TO (c) <b>urethral obstruction</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>18</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>19</b> and that death occurred at <b>5:18</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>E. C. H. Schmidt</b>				22b. DATE SIGNED <b>14 June 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>				22d. ADDRESS <b>Easton, Maryland</b>			
23a. BURIAL CREMATION REMOVAL (specify) <b>burial</b>		23b. DATE THEREOF <b>June 16, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hillabore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James C. Patchett</b>				25a. REC'D BY REGISTRAR <b>DATE JUN 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Clifford L. Hume</b>	

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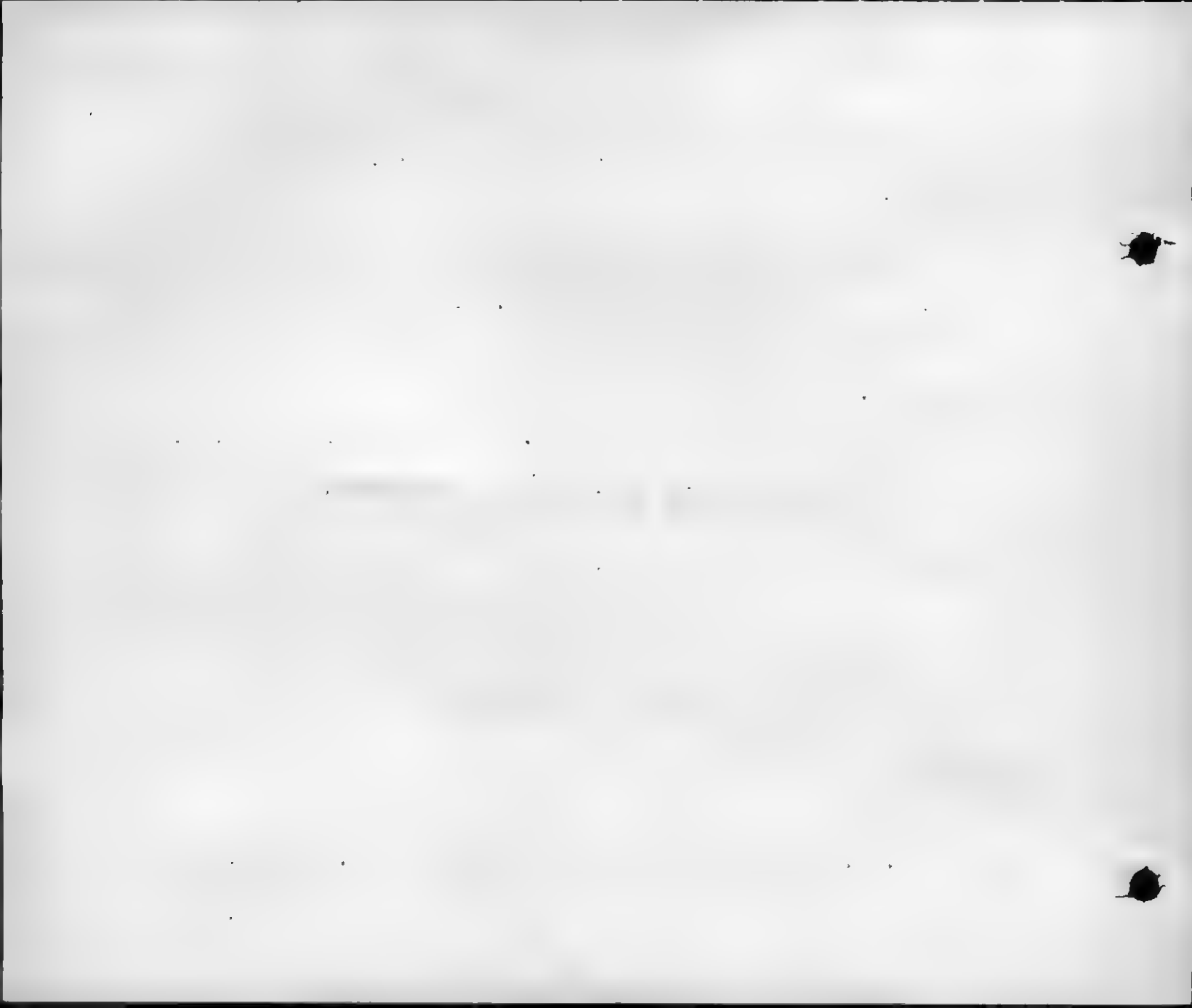


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
07205

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>13 hrs 45 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural-Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>				d. STREET ADDRESS <u>1 none</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <del>XXXXXX</del> <u>Mable</u> <u>Dunham</u> <u>Potter</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>13</u> <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26, 1874</u>	
9. AGE (n years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marvin H. Dunham</u>				14. MOTHER'S MAIDEN NAME <u>Emily Herron</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>none</u>		17. INFORMANT Address <u>Mrs. Curtis Jones, Easton, RD, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/12</u> , 19 <u>61</u> , to <u>6/13</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/13</u> , 19 <u>61</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>L. J. Eglseder</u>				M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 22	
22c. PHYSICIAN'S NAME (Type) <u>L. J. Eglseder</u>				22d. ADDRESS <u>Hanson St. Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Old Wye Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Wye Mills, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Carroll</u>				ADDRESS <u>EASTON, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 19 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	



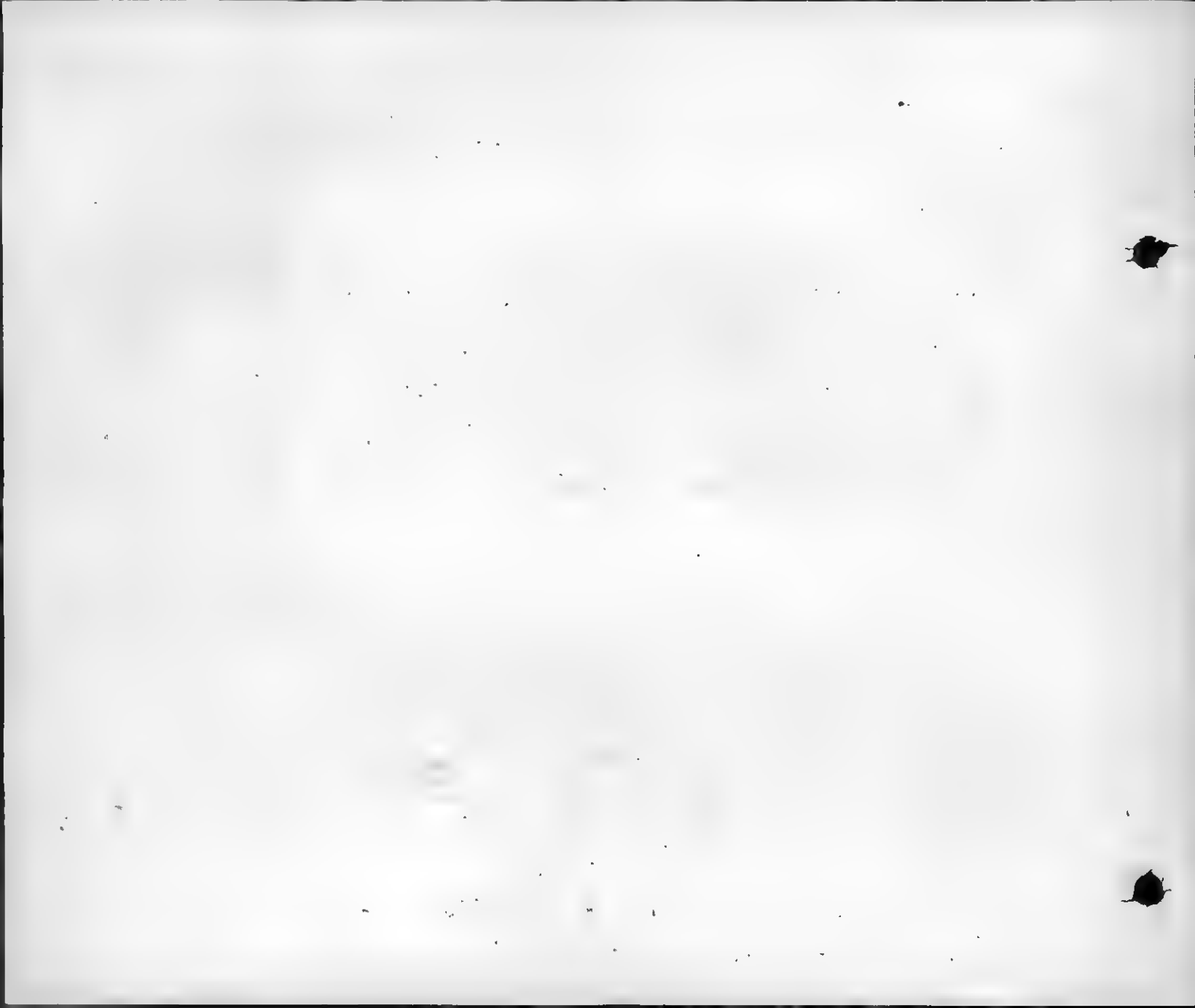
## CERTIFICATE OF DEATH

Reg. Dist. No. 07206

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TILGHMAN</b>		c. LENGTH OF STAY IN 1b <b>56 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AT HOME, Tilghman MD.</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>CAMPER</b> Middle <b>H.</b> Last <b>Scharch</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 15 1905</b>
9. AGE (In years last birthday) <b>56 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL</b>	
11. BIRTHPLACE (State or foreign country) <b>Tilghman Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>AMIL Scharch</b>		14. MOTHER'S MAIDEN NAME <b>MARY NIBBETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs Gretchen Scharch, Tilghman</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERCUTED BY TRUCK.</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>DEC 1960</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JAN 29 1961</b> to <b>JAN 29 1961</b> , that I last saw the deceased alive on <b>JAN 29 1961</b> and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>ROY M REESER Sr</b> M.D.		ADDRESS (Street, city or town, state) <b>TILGHMAN Md R-1-61</b>	
PHYSICIAN'S NAME (Type) <b>ROY M REESER Sr</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 3-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sherwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Sherwood Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stamberton Harrison, St. Michael</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '61</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

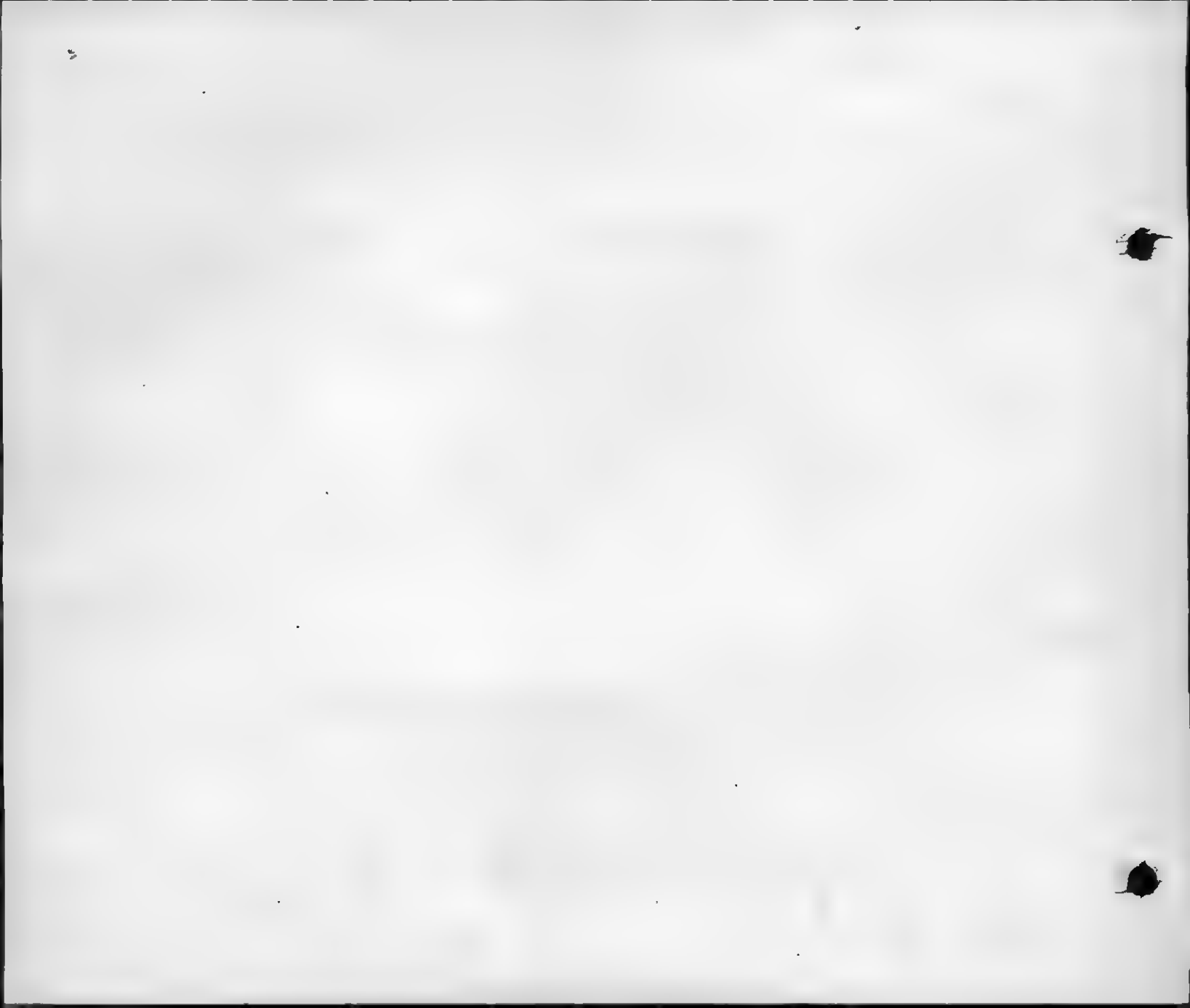




may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

7218		07207	
1 PLACE OF DEATH a. COUNTY <i>Talbot</i>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton (Rural)</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton (Rural)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>HENRY M. SHORTALL SR.</i>		4. DATE OF DEATH <i>June 10 1961</i>	
5 SEX <i>Male</i>	6 COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 19, 1904</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William John Shortall</i>		14. MOTHER'S MAIDEN NAME <i>Maudie Ethel Andrew</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>219-34-4022</i>	
17. INFORMANT <i>H. Michael Shortall Jr.</i>		Address <i>Easton Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary artery occlusion</i> 420.1 DUE TO <i>Coronary artery disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>uncommon</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>uncommon</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>T.B. of R. lungs, far advanced, arrested. Pulmonary</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>Dec 3, 1961</i> to <i>June 10, 1961</i> , that (I) (we) last saw the deceased alive on <i>June 1, 1961</i> , and that death occurred at <i>12:30</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Kurt Lederer</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>KURT LEDERER</i>		22d. ADDRESS <i>QUEEN ANNE MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>June 13, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City, town, or county) (State) <i>Easton Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice E. Newnam</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Hume</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>JUN 16 '61</i>	



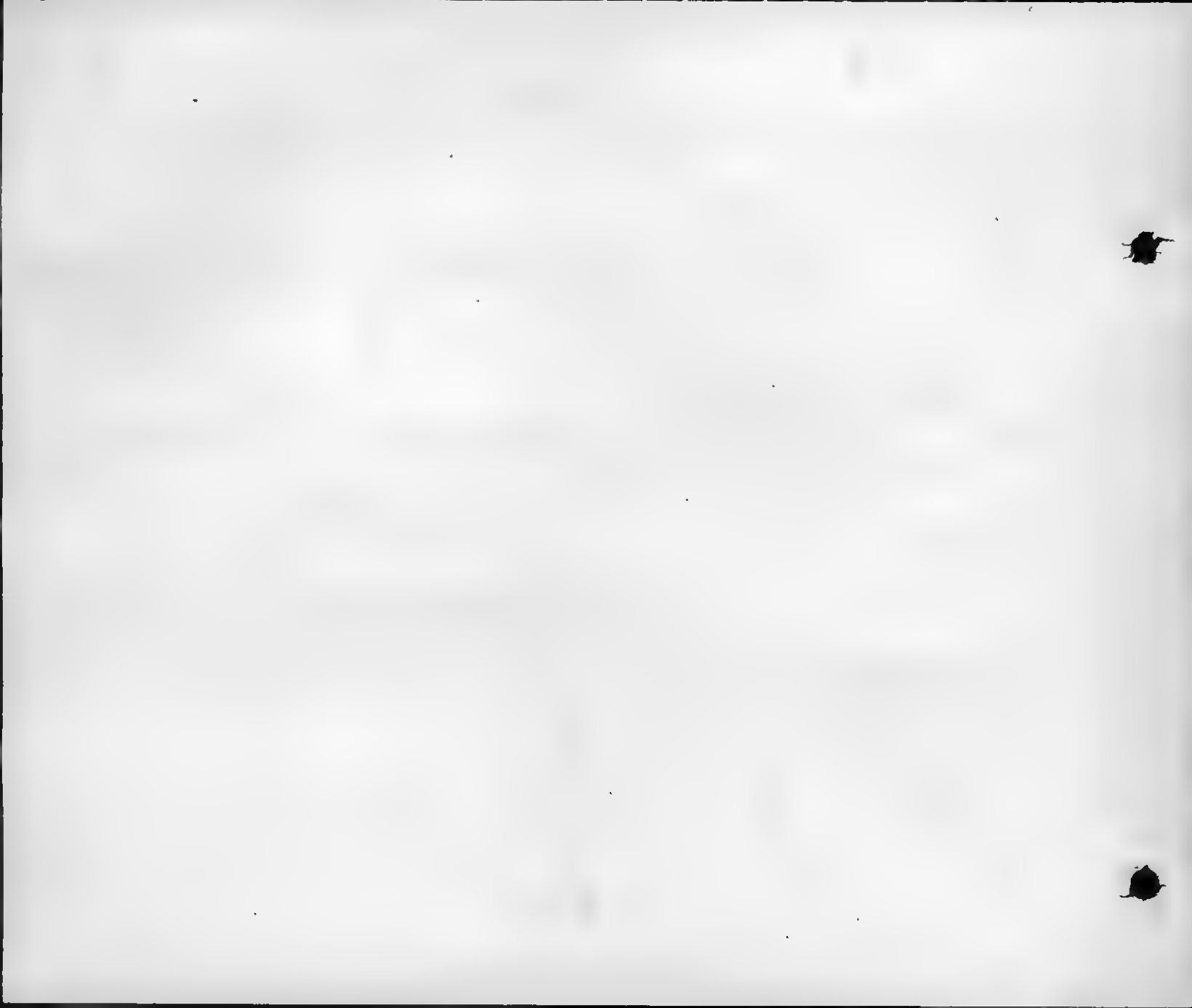
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

07203

7219

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Valerie</u> Middle <u>Ann</u> Last <u>STURGIS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (in years lost birthday) <u>June 10, 1960</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Sturgis</u>				14. MOTHER'S MAIDEN NAME <u>Annette Simmons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Annette Simmons - Avalon, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute purulent meningitis</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19__				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I, this hospital) attended the deceased from _____ 19__ to _____ 19__ that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at <u>8 p.m.</u> from the causes and on the date stated above							
22a. SIGNATURE <u>E. C. H. Schmidt</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE <u>12 June 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edmund Schmidt</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Betham Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Betham, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Donnell</u>				ADDRESS <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 14 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

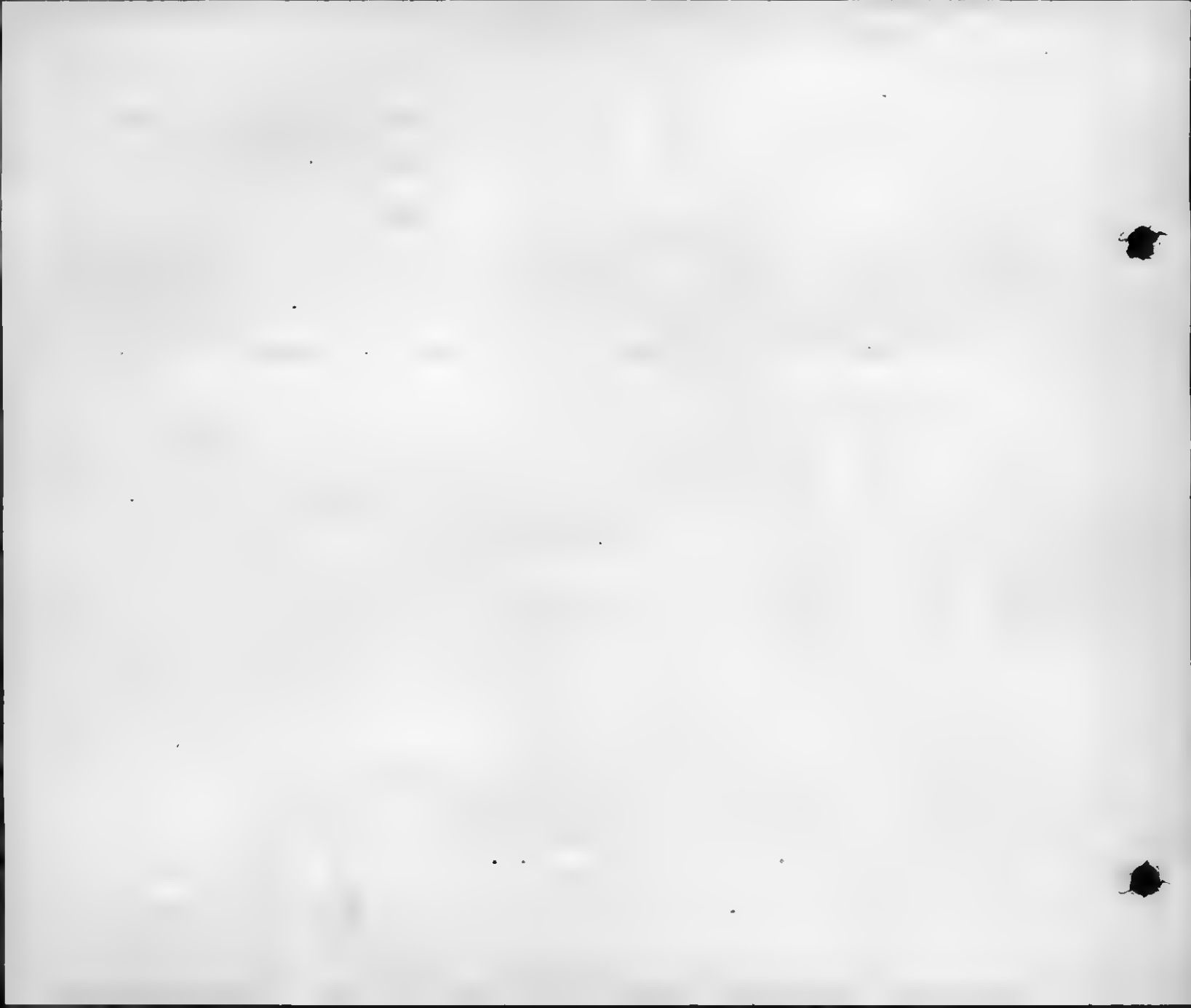
7220

08477

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston - Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Harmony Road</u>			
3. NAME OF DECEASED (Type or print) <u>Bertha Elizabeth Taylor</u>				4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 14, 1890</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>30</u> Hours <u>30</u> Min.		IF UNDER 24 HRS Months <u>6</u> Days <u>30</u> Hours <u>30</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Deen</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Willis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lee E. Messick, Preston, Md., R.F.D.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>170X</u> IMMEDIATE CAUSE (a) <u>Carcinoma of the breast - widespread</u> DUE TO (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1961</u> to <u>June 1961</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> 19 <u>61</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Trever</u>				22b. ADDRESS <u>M.D. Easton, Maryland</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>				22d. ADDRESS <u>M.D. Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 2, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Federalburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Q. J. Frampton and Son</u> ADDRESS <u>Federalburg</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

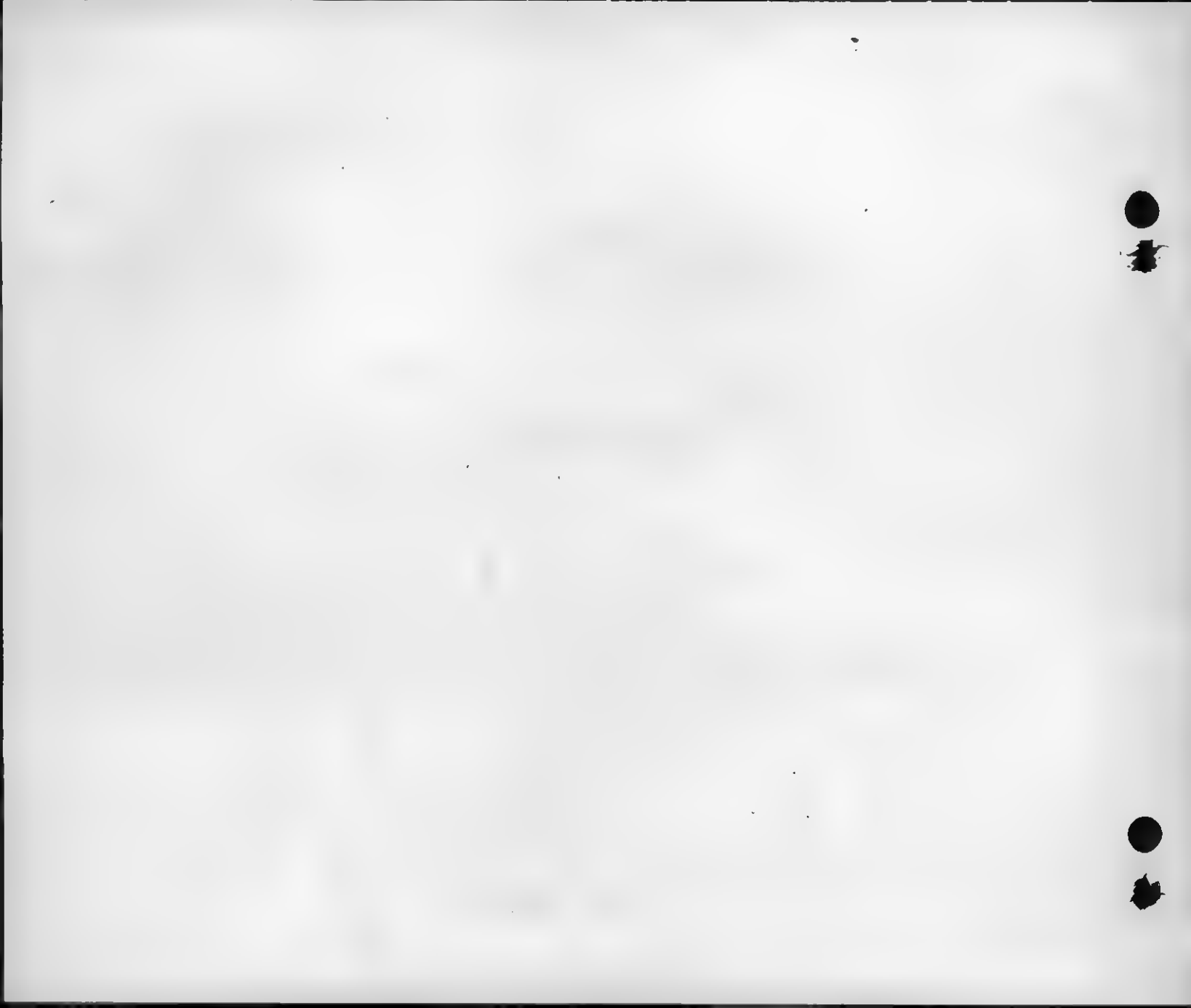
VR A15 (4)  
ISM 9/59

7221

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07209

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Abraham</b> Middle <b>Tilghman</b> Last <b>Tilghman</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/81</b>
9. AGE (In years lost birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR <input checked="" type="checkbox"/> UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Hand</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Perry H. Tilghman</b>		14. MOTHER'S MAIDEN NAME <b>to Easton Carol</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>219-05-8818</b>	
17. INFORMANT <b>Bert Cook, Grasonville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Infarct, right</b> DUE TO <b>Cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>Advanced arteriosclerosis</b> DUE TO (b) <b>Advanced arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <b>19</b> to <b>19</b> , that (1) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>7:30 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>E.C.H. Schmitt</b>		22b. DATE <b>19 June 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>E.C.H. Schmitt</b>		22d. ADDRESS <b>Easton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-22-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bryans Ch. Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Grasonville, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Dabul</b>		25a. REC'D BY REGISTRAR <b>JUN 23 '61</b>	
ADDRESS <b>Easton Md.</b>		25b. REGISTRAR'S SIGNATURE <b>James B. Dabul</b>	





TO HOSPITAL or RETIREMENT by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

Page 4

ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2, should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7222

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07210

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTON Memorial Hosp</u>		d. STREET ADDRESS <u>55X-2</u>	
3 NAME OF DECEASED (Type or print) First <u>Glady's</u> Middle <u>MARY</u> Last <u>TRICE</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1961</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 11, 1903</u>
9. AGE (in years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM PHILLIPS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Herman Dodd</u>		Address <u>Denton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>493</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1960</u> to <u>June 1961</u> , that (I) (we) last saw the deceased alive on <u>June 1961</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>P. E. Cox</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>		22d. ADDRESS <u>Easton, Maryland</u>	
22e. DATE SIGNED <u>6/7/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 8, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		23d. LOCATION (City, town, or county) (State) <u>DENTON, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Varga Moore</u>		ADDRESS <u>Soc. Denton, Md.</u>	
25a. REC'D BY REGISTRAR <u>JUN 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Reg. Dist. No. **07211**

**7223**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Talbot</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> c. LENGTH OF STAY IN lb <b>25 Min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Henderson</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Orban</b> <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>5-25-1880</b> <b>9. AGE</b> (In years last birthday) <b>81</b> yrs.		<b>4. DATE OF DEATH</b> Month <b>6</b> Day <b>30</b> Year <b>19 61</b> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farm Owner</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Hungary</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>Hungary</b>	
<b>13. FATHER'S NAME</b> <b>No Record</b> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>219-34-4072A</b> <b>17. INFORMANT</b> <b>Mary Voycsik Henderson, Maryland</b> <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Arterio Sclerosis Generalized</b> DUE TO (c) <b>5 yrs -</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4 hrs -</b>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></b> <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input "="" checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></b>			
<b>ACTUAL SIGNATURE</b> <b>Dawson O. George</b> <b>EXAMINER'S NAME (Type)</b> <b>Dawson O. George</b>		<b>CHIEF MEDICAL EXAMINER <input type="checkbox"/></b> <b>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></b> <b>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></b> <b>DATE SIGNED</b> <b>9-1-61</b>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>7-3-61</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Greensboro</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Greensboro, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>1-8-61</b> <b>ADDRESS</b> <b>Baltimore, Maryland</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE JUL 5 '61</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the necessary pages are missing, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



7224

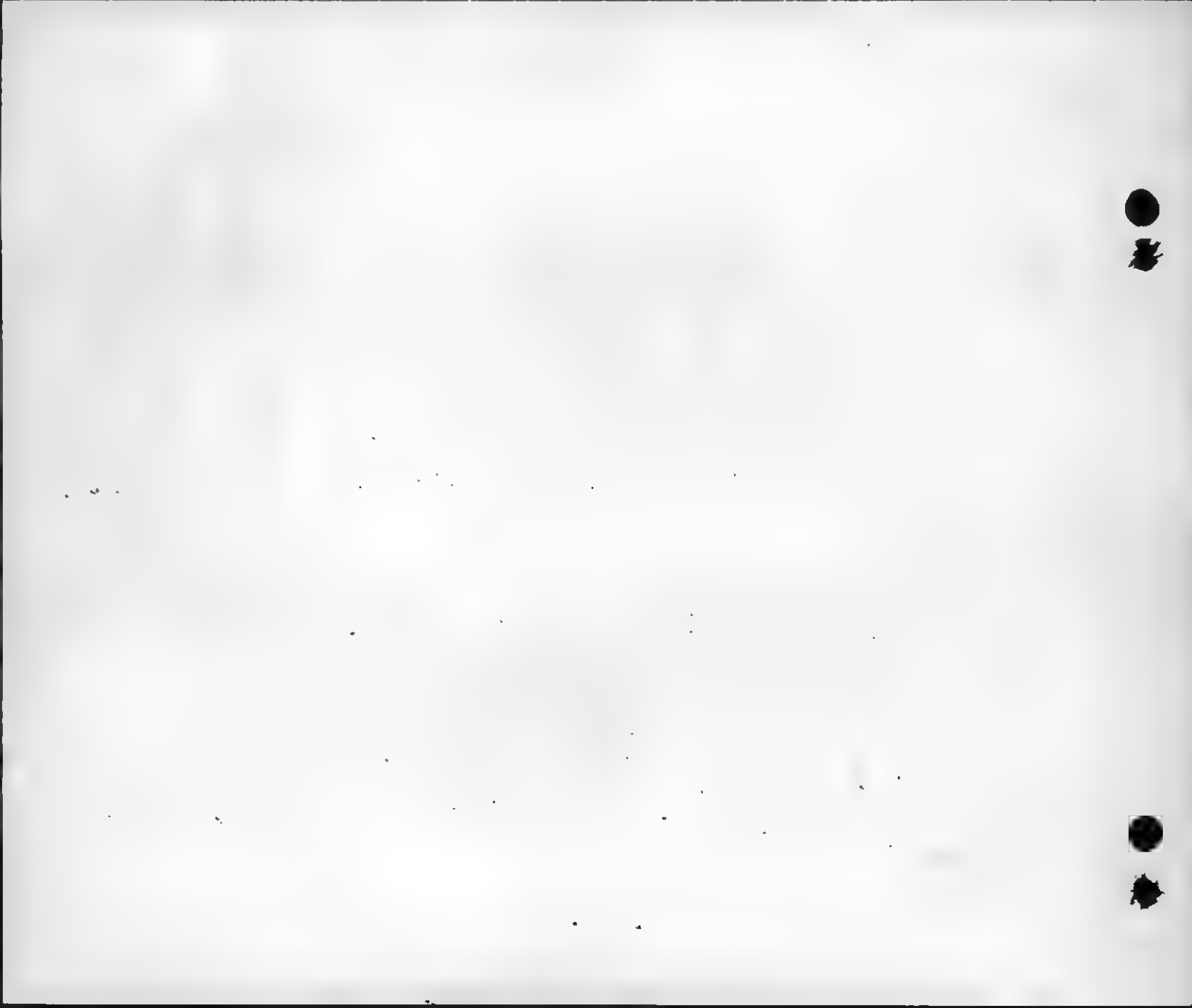
## CERTIFICATE OF DEATH

Reg. Dist. No. 07212

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. MICHAELS</b>		c. LENGTH OF STAY IN 1b <b>50 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AT HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FREDRICK</b> First <b>WATERS</b> Middle <b>WATERS</b> Last		4. DATE OF DEATH <b>JUNE</b> Month <b>29</b> Day <b>1961</b> Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 16. 1892</b>
9. AGE (In years last birthday) <b>69 yrs</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>29</b> Hours <b>15</b> Min <b>00</b>	11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. WATERS</b>		14. MOTHER'S MAIDEN NAME <b>MATILDA J. SAMSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address <b>Madge Waters, St. Michaels, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>Hypertensive Cardiovascular Dis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 mos</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> 19 <b>61</b> to <b>29 June</b> 19 <b>61</b> that I last saw the deceased alive on <b>28 June</b> 19 <b>61</b> and that death occurred at <b>9:15 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. Paul Wright</b>		ADDRESS (Street, city or town, state) <b>Box 487 St. Michaels, Md</b> DATE SIGNED <b>7-1-61</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>7-3-61</b>	<b>Thomas Memorial</b>	<b>St. Michaels, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hamberton Harrison, St. Michaels</b>		24a. REC'D BY REGISTRAR <b>JUL 6 61</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Wm. S. Smith</b>	

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the signature of the attending physician. The law requires that the death certificate be executed with the signature of the attending physician. The law requires that the death certificate be executed with the signature of the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07213

7225

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp. Tal</u>				d. STREET ADDRESS <u>121 N. Locust Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vera</u> Middle <u>Muriel</u> Last <u>Watson</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1905</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alfred Kline</u>				14. MOTHER'S MAIDEN NAME <u>Schumine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Ronald Philip Watson, Easton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Memoria</u> <u>154X</u> DUE TO (b) <u>Obstructive uropathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>ca of rectum &amp; metastasis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-55</u> to <u>6/21/1961</u> , that (I) (we) last saw the deceased alive on <u>6/1-1961</u> and that death occurred on <u>6/21/61</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>P. E. Cox</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>P. E. Cox</u>				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Redmen Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chincoteague, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Langston Carroll, EASTON, MD</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 26 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed with the physician's signature after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7225

07214

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - ST. MICHAELS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - ST. MICHAELS</b>			
c. LENGTH OF STAY IN 1b <b>17 YRS.</b>				d. STREET ADDRESS <b>1 -</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>-</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>W.</b> Last <b>WILSON</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>13</b> Year <b>1961</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 7, 1879</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEF - COOK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM WILSON</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>235-26-5617</b>		17. INFORMANT <b>MRS. C.W. WILSON</b> Address <b>CHELSEA FARM ST. MICHAELS, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Congestive Heart Fail</b> DUE TO (b) <b>Coronary Artery Heart Dis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>1 yr.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mon</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>14 Jan 1961</b> to <b>12 June 1961</b> , that (I) <del>met</del> last saw the deceased alive on <b>11 June 1961</b> , and that death occurred at <b>8:15 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>R. Lane Croft</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JUNE 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MARLINGTON</b>		23d. LOCATION (City, town, or county) (State) <b>MARLINGTON, W. VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hampton Harrison, St. Michaels Md</b>				24a. ADDRESS		24b. DATE <b>JUN 14 '61</b>	

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